

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE COMMISSIONER OF HEALTH

In the Matter of the Maltreatment and  
Disqualification Appeals of Dave Lloyd  
Kulee

**FINDINGS OF FACT, CONCLUSIONS  
AND RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Linda F. Close on July 20, 2006, at the Office of Administrative Hearings, 100 Washington Ave. S., Minneapolis MN 55401-2138. The record closed at the end of the hearing day.

Audrey Kaiser Manka, Assistant Attorney General, 1200 NCL Tower, 445 Minnesota St., St. Paul, MN 55102-2130, appeared on behalf of the Department of Health (Health Department).

Daniel G. Prokott and Megan Hladilek, Faegre & Benson, 2200 Wells Fargo Center, 90 South Seventh St., Minneapolis MN 55402-3901 appeared on behalf of Dave Lloyd Kulee (Respondent).

**STATEMENT OF THE ISSUES**

1. Does a preponderance of the evidence demonstrate that Respondent committed an act of maltreatment by abuse against a vulnerable adult on October 24, 2005?
2. Did the Department of Human Services (Human Services) correctly disqualify Respondent from employment having direct contact with persons receiving services from licensed programs and facilities?
3. Did the Health Department correctly refuse to set aside the disqualification?

Based on the evidence in the hearing record, the Administrative Law Judge makes the following:

**FINDINGS OF FACT**

1. Respondent came to the United States as a refugee from Liberia in 2000.<sup>[1]</sup> After he arrived, he worked as a janitor for about three years.<sup>[2]</sup>

Beginning in March 2004, he worked as a nursing assistant at Woodbury Health Care Center.<sup>[3]</sup> He also worked as a nursing assistant at a variety of other health care facilities through three different staffing agencies.<sup>[4]</sup>

2. On September 26, 2005, Respondent began working as a Human Services Technician (HST)<sup>[5]</sup> at the Minnesota Veterans Home (MVH).<sup>[6]</sup> This entailed a pay cut, but Respondent wanted to contribute to the public, because he feels a debt of gratitude for having been allowed to come to the United States.<sup>[7]</sup>

3. Respondent is currently enrolled at Brown College, Mendota Heights MN. He is majoring in Criminal Justice and expects to receive his degree in June 2007.<sup>[8]</sup>

4. LD was a resident of MVH until he died sometime after the incident giving rise to this appeals hearing. Because of a stroke, LD's left side was paralyzed and he required complete care, including feeding, bathing, and dressing. He used a wheelchair and was transferred to and from his bed using a mechanical lift. The lift is meant to be operated by two persons.<sup>[9]</sup> LD could communicate, but he had to be listened to carefully, because his speech was impaired.<sup>[10]</sup> As of September 13, 2005, LD was 5'6" and weighed 175 pounds.<sup>[11]</sup>

5. LD suffered from long and short-term memory deficits.<sup>[12]</sup> On July 18, 2005, he was administered a mini-mental status exam. At that time, he identified the date as March 19, 1965. His total score on the mental status exam was 15 out of 29.<sup>[13]</sup>

6. James Doran is a senior social worker at MVH. He knew LD well and communicated with him frequently. On October 25, 2005, at 11:15 a.m., LD reported to his wife and then to Doran that the person<sup>[14]</sup> who had put him into bed the night before had treated him roughly. LD said that the person had put LD into bed without using the mechanical lift. LD said he had been tossed into bed instead, although he asked the person to use the lift. According to LD, the person said "I'll do it my way," and then tossed LD into bed. LD said the person had been wearing a sweatshirt with the number 74 or 84 on it. He described the person as "a large black man." LD reported the incident as having occurred at 11:30 p.m. the prior evening. Doran did not notice any bruising on LD. He did notice that LD was visibly upset as he spoke with Doran. Doran had no knowledge of LD ever making false reports.<sup>[15]</sup>

7. Doran reported the incident to Lavonne Tiaden, the RN manager supervisor on duty that morning. LD told Tiaden that the HST<sup>[16]</sup> had been "rough with me doing cares" the previous evening. Tiaden and another nurse, Laurie Flora, undertook a head-to-toe assessment of LD's body. They found a hematoma on LD's left hand, three areas of petechiae<sup>[17]</sup> on the left forearm, and five superficial scratches on LD's lower abdomen.<sup>[18]</sup>

8. Sue Garretson is the Assistant Director of Nursing at MVH. Tiaden called Garretson to relay LD's rough treatment report. Garretson then interviewed LD herself. LD told her that he had requested a mechanical lift be used for his transfer to bed, but that the person who put him into bed instead "dumped him" there. LD said that the person who did this wore an athletic shirt with the number 43 on it.<sup>[19]</sup> LD did not identify by name the person who tossed him into bed, but he did say it was a black man. LD was upset and forceful in describing what happened to him.<sup>[20]</sup> With LD's consent, Garretson photographed the bruises and scratches.<sup>[21]</sup> LD's injuries, under Department of Veterans Affairs (DVA) definitions, would be considered minor. As a result, MVH did not have to be reported to DVA. Bruising of a resident can occur even during appropriate care.<sup>[22]</sup>

9. Garretson believes it would be possible for a person to have lifted LD, although she herself could not have done so, and she would not have attempted that. Lifting LD would have meant lifting 175 pounds of dead weight. LD's allegation that this had happened surprised Garretson.<sup>[23]</sup>

10. Garretson approved the Agency Resident Incident Report that was prepared in connection with LD's allegations. Garretson noted that the report indicated the time of the incident as 23:30 on the evening of October 24<sup>th</sup>. Garretson discounted that information, however, because she thought it could not be correct.<sup>[24]</sup>

11. MVH prepares an HST Worksheet for each resident. This worksheet provides the HST with information about the cares to be provided each resident. LD was incontinent, so cares included checking him for toileting cares. The head of his bed had to be maintained at 30 degrees, and he was required to be repositioned in bed every two hours.<sup>[25]</sup>

12. Respondent worked the 2:30 p.m. to 11:00 p.m. shift on October 24, 2005. Respondent is 5'6" and, at that time, weighed about 150 pounds. He did not wear an athletic jersey to work, and he does not own one like that described by LD. Respondent's assignment that evening included cares for LD.<sup>[26]</sup> Laura Mayaka, a fellow HST at MVH, helped Respondent transfer LD from his bed around 4:30 p.m. on October 24, 2005.<sup>[27]</sup> She did not assist Respondent in transferring the VA back to bed for the night, although Respondent believes that she did.<sup>[28]</sup> No one besides Respondent was in the room when LD was put to bed.

13. Respondent put LD to bed around 9:30 p.m. on October 24<sup>th</sup>.<sup>[29]</sup> It is possible for one person to use the mechanical lift, although two persons are supposed to operate it.<sup>[30]</sup> After getting LD into bed, Respondent changed LD because LD was wet. To do this, Respondent rolled LD toward the wall, but LD did not bump into the wall when this happened.<sup>[31]</sup> Sometime after 9:30, LD put on his call light. Mayaka, Respondent, and another HST went into LD's room,

but LD did not want anything, and they left. Respondent was in bed by that time.<sup>[32]</sup> Respondent has denied going into the room with the other HSTs.<sup>[33]</sup>

14. Among the HSTs who worked at MVH at the time of the incident, there was only one white HST. The others were all black.<sup>[34]</sup>

15. The Health Department, through its Office of Health Facility Complaints (OHFC), investigates alleged violations of the Vulnerable Adults Act. Investigators Kristine Lohrke and Eileen Dejdar conducted the investigation pertaining to LD's allegations. Interviews of MVH employees took place between December 2, 2005 and March 8, 2006.<sup>[35]</sup>

16. On December 2, 2005, the OHFC investigators attempted to interview LD about the October 24<sup>th</sup> incident, but LD could not recall the incident at all.<sup>[36]</sup>

17. During the OHFC investigation, Sue Garretson told the investigators that she had verified with three employees that Respondent wore a sports jersey with a number on the back at work on October 24<sup>th</sup>. However, on interview by OHFC, one of the three employees stated that Respondent wore a long-sleeved red sweater at work that evening; another said Respondent wore a jersey, but was unsure of the color; and the third couldn't recall what Respondent had worn that evening.<sup>[37]</sup>

18. During the OHFC investigation, Respondent told the investigators that a housekeeping person came into LD's room to empty the trash when Respondent was transferring LD. The housekeeping person was interviewed and stated he did not go into LD's room to empty the trash that evening. Respondent also stated that another HST, Jerry Cooper, entered LD's room during the transfer.<sup>[38]</sup> Cooper denied coming into the room, however.<sup>[39]</sup>

19. The investigators concluded that maltreatment had occurred and that Respondent was the one responsible.<sup>[40]</sup> They concluded this because LD had stated to several people that the person who had hurt him was the person who had put him to bed. Respondent admitted to putting LD to bed. In reaching their conclusion, the investigators disregarded LD's account of the time of the incident because Mayaka and others had seen LD in bed when LD put on the call light. They also discounted LD's identification of the numbered jersey, because they never found out who owned such a jersey.<sup>[41]</sup>

20. It was significant in the investigators' conclusion that Respondent had incorrectly reported Mayaka's help in operating the lift at bedtime. The investigators interviewed all the HSTs, and all denied helping Respondent put LD to bed on the 24<sup>th</sup>. There were other inconsistencies in Respondent's account that played a part in the conclusion that Respondent had abused LD.<sup>[42]</sup> It was also significant for the investigators that LD had reported a "large black man" as

the person who put him to bed. Although Respondent is only 5'6" and only 150 pounds, the investigator believed LD could perceive Respondent as large.<sup>[43]</sup>

21. In a report dated March 10, 2006, the OHFC investigators found that Respondent had committed maltreatment of a vulnerable adult.<sup>[44]</sup> On April 5, 2006, the Health Department notified Respondent of its finding.<sup>[45]</sup> On April 19, 2006, Respondent requested reconsideration of the maltreatment determination.<sup>[46]</sup> On May 4, 2006, the Health Department informed Respondent it would not change its maltreatment determination.<sup>[47]</sup> Respondent requested a fair hearing by a letter dated May 8, 2006.<sup>[48]</sup>

22. Meanwhile, the OHFC report was submitted to the Minneapolis City Attorney's office for prosecution. By a letter dated May 6, 2006, the City Attorney declined to prosecute Respondent.<sup>[49]</sup>

23. Based on the OHFC maltreatment determination, the Human Services Department found the maltreatment serious and disqualified Respondent from any position of direct contact with persons receiving services from facilities licensed by it or the Health Department. The Department notified Respondent of the disqualification on May 1, 2006.<sup>[50]</sup> On May 6, 2006, Respondent requested reconsideration of the disqualification.<sup>[51]</sup> In accordance with Minn. Stat. § 144.057, subd. 3, the Health Department reviewed the reconsideration request. By a letter dated May 26, 2006, the Health Department refused to set aside the disqualification.<sup>[52]</sup> Respondent thereupon requested a fair hearing in a letter dated June 2, 2006,<sup>[53]</sup> resulting in this consolidated appeals hearing.

Based on these Findings of Fact, the Administrative Law Judge makes the following:

## **CONCLUSIONS**

1. The Administrative Law Judge and the Commissioner of Health have jurisdiction over this matter pursuant to Minn. Stat. §§ 14.50, 144.057, 245C.28 and 626.557-5572.

2. Proper notice of the hearing was timely given and all relevant substantive and procedural requirements of statutes and rules have been fulfilled.

3. Minn. Stat. § 626.5572, subd. 2(b) defines "abuse" of a vulnerable adult to mean "[c]onduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following: (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult . . . ."

4. Minn. Stat. § 245C.15, subd. 4 (b) (2) provides that an individual shall be disqualified from any position allowing direct contact with persons

receiving services from a program licensed by the Health Department if there has been a determination or disposition of substantiated serious or recurring maltreatment of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment.

5. Minn. Stat. § 245C.22, subd. 2 specifies that, upon a request for reconsideration of a disqualification, the Commissioner must rescind the disqualification if the Commissioner finds that the information relied on to disqualify the individual is incorrect.

6. The Health Department has not proved by a preponderance of the evidence that the Respondent committed maltreatment in connection with the October 24, 2005, incident.

7. Respondent is not disqualified from direct contact with persons receiving services from a facility licensed by the Health Department because he did not commit serious maltreatment of a vulnerable adult.

8. The Administrative Law Judge adopts as Conclusions any Findings that are more appropriately described as Conclusions.

Based upon these Conclusions, and for the reasons explained in the accompanying Memorandum, the Administrative Law Judge makes the following:

## **RECOMMENDATION**

Based upon these Conclusions, the Administrative Law Judge recommends that: the finding of substantiated maltreatment and the decision to disqualify Respondent be RESCINDED.

Dated: August 17, 2006

/s/Linda F. Close

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LINDA F. CLOSE

Administrative Law Judge

Reported: Taped, 3 tape(s)  
No transcript prepared

## **NOTICE**

This report is a recommendation, not a final decision. The Commissioner of Health (the Commissioner) will make the final decision after a review of the record. The Commissioner may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendations. Under Minn. Stat. § 14.61, the final decision of the Commissioner shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact Dianne Mandernach, Commissioner, Department of Health, 625 N. Robert Street, P.O. Box 64975, St. Paul, MN 55164-0975, (651) 201-5810, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the Report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

## MEMORANDUM

Abuse of vulnerable adult cases present difficult problems of proof. This case exemplifies these problems. LD sustained injuries sometime during the evening hours of October 24, 2005, or at some point overnight. About that, there is no doubt. No one except LD and the person who injured LD witnessed the events, and there is no doubt of that, either. LD says that the person who put him to bed is the one who hurt him; Respondent admits he put LD to bed that night. Beyond that, however, LD's description of what happened and who did it can not be reconciled to say that it is more likely than not that Respondent was the individual who hurt LD.

The ALJ finds persuasive Respondent's argument that the Health Department's selective use of portions of LD's account cannot be the basis for a maltreatment determination. LD's first reports were very specific: someone wearing an athletic shirt with the numbers 84 or 74 on it treated him roughly when putting him to bed without a mechanical lift.<sup>[54]</sup> This happened at 11:30 that night, according to LD, and the person who treated him roughly was a large black man. Respondent had left the facility by 11:30, he did not wear or even own a numbered athletic shirt, and he is not a large man.

The ALJ's conclusions may appear inconsistent with the finding that Ms. Mayaka's testimony is more credible than Respondent's on the issue of putting LD to bed. Although it does appear that Respondent put LD to bed on his own, without assistance, it was possible to do this by operating the lift himself.<sup>[55]</sup> This was against MVH policy, and Respondent should not have done that. But three HSTs came to LD's room soon after LD was put to bed. LD was not in distress and had no complaints.<sup>[56]</sup> Apparently, no one saw that he was injured or that he acted as if he had been.

It is concerning here that Garretson pointed OHFC investigators in Respondent's direction by telling them that three MVH employees had identified Respondent as wearing a numbered white, athletic shirt on the evening of the incident. This was not true. One employee stated positively that Respondent wore a long-sleeved, red sweater or sweatshirt; the second thought he wore an athletic shirt, but didn't know the color; and the third couldn't remember at all what Respondent was wearing.

The Health Department investigation thus appears to have proceeded from a false premise. In addition, the investigation did not even start until nearly six weeks after the incident. By then, LD, the most important witness to the events, could not recall it ever happening. The investigation relied in large part on a process of elimination of other likely perpetrators to target Respondent. While such an investigative technique might be legitimate in some other case, here, even the process of elimination does not lead inevitably or even probably to Respondent. LD had to be moved every two hours, even at night.<sup>[57]</sup> It is possible that the injury occurred during one of these checks. Since LD was put to bed

around 9:30, the check should have been around 11:30, the very time LD identified as the time of the incident. By that hour, it is possible that LD was confused about the injury occurring while he was being put into bed.

Finally, it is also of concern that LD's injuries were very slight, whereas the maltreatment finding has great consequences for Respondent. They were injuries of a type that can occur during normal care.<sup>[58]</sup> The injuries were minor under DVA definitions, and did not even require reporting.<sup>[59]</sup> Thus, it is questionable whether maltreatment should have been found, and even more questionable whether it should have been characterized as "serious."<sup>[60]</sup> Although any intended injury should not be tolerated, when the injuries are slight, as here, it is important to put the Health Department to its proof. The evidence presented does not come up to the preponderance standard.

Because the ALJ finds no maltreatment, it follows there is no basis for disqualification.

### **L.F.C.**

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- [1] Testimony of Respondent.
  - [2] Ex. 7.
  - [3] Ex. 7.
  - [4] Test. of Respondent.
  - [5] An HST is a certified nursing assistant. Testimony of Lavonne Tiaden.
  - [6] Ex. 7; Test. of Respondent.
  - [7] Test. of Respondent.
  - [8] Ex. 7; Test. of Respondent.
  - [9] Test. of L. Tiaden; Ex. 1, p. 2. MVH policy requires two staff during the use of the mechanical lift. See Ex. 4.
  - [10] Ex. 1, p. 2; Test. of L. Tiaden.
  - [11] Ex. 9 (MDS Quarterly Assessment Form); Test. of L. Tiaden.
  - [12] Test. of L. Tiaden.
  - [13] Ex. 9, p. 4.
  - [14] Testimony of James Doran.
  - [15] Test. of J. Doran.
  - [16] In testifying, Tiaden referred to the person as an HST. On cross examination, she admitted that LD had not actually used the term HST.
  - [17] These were small areas of bleeding under the skin. Test. of L. Tiaden.
  - [18] Test. of L. Tiaden Testimony; Ex. 9. p. 2; Testimony of Laurie Flora.
  - [19] During the Health Department's investigation, Garretson referred to the shirt number as 43. At hearing, she referred to it as number 42.
  - [20] Testimony of Sue Garretson; Ex. 1, p. 4.
  - [21] Ex. 10 consists of the photos Garretson took.
  - [22] Test. of S. Garretson.
  - [23] Test. of S. Garretson.
  - [24] Test. of S. Garretson; Ex. 3.
  - [25] Test. of S. Garretson; Ex. 13.

[26] Test. of Respondent.  
[27] Testimony of Laura Mayaka.  
[28] Test. of L. Mayaka; Test. of Resp.  
[29] Test. of Respondent.  
[30] Testimony of Francis Dewarod.  
[31] Test. of Respondent; Ex. 1, p. 6.  
[32] Test. of L. Mayaka.  
[33] Test. of Respondent.  
[34] Test. of L. Mayaka.  
[35] Ex. 1.  
[36] Ex. 1  
[37] Ex. 1.  
[38] Ex. 1.  
[39] Ex. 1.  
[40] Ex. 1, p. 7; Testimony of Eileen Dejdard..  
[41] Test. of E. Dejdard.  
[42] Test. of E. Dejdard.  
[43] Test. of Dejdard.  
[44] Ex. 1.  
[45] Ex. 14.  
[46] Ex. 15.  
[47] Ex. 16.  
[48] Ex. 17.  
[49] Ex. 47; Test. of E. Dejdard.  
[50] Ex. 20.  
[51] Ex. 26.  
[52] Ex. 34.  
[53] Ex. 38.  
[54] Test. of J. Doran.  
[55] Test. of F. Dewarod.  
[56] Test. of L. Mayaka. LD had rung for assistance when he needed none at other times as well. Test. of L. Mayaka.  
[57] Test. of S. Garretson.  
[58] Test. of S. Garretson; Test. of L. Mayaka.  
[59] Test. of S. Garretson.  
[60] Technically, the Human Services Department (and the Health Department upon reconsideration) could reach the conclusion of "serious" maltreatment based upon Minn. Stat. § 245C.02, subd. 18, which may be read to mean that any bruise constitutes "abuse resulting in serious injury." Given that an elderly person can sustain a bruise accidentally, application of the "serious" category should be undertaken advisedly when bruising is the injury.